EXHIBIT 601.6

Patient Name: Dan McCormack

Date 8/16/04

Medication	8/16/04	3/17/05	8/10/05	3/28/06	8/24/06	3/2/07	4/30/07	6/4/07	9/6/07	12/5/07	4/3/08		
Diltiazem CD 300mg q AM	✓	✓	✓	✓	✓	–	✓	✓	✓	✓	✓		
Diltiazem CD 180mg q pm	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Lanoxin 0.25mg tbid	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Allopurinol 100mg tid qd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Protonix 40mg qd	✓	Add											
ASA 325mg qd	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Prevacid 30mg qd		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Indocin pm				✓	✓	✓	✓	✓	✓	✓	✓		

Adverse Reactions: Sulfa; Ampacillin; Septra

SIMVASTATIN → nausea

EXHIBIT 6

PENGAD 800-631-6989

9/97 #FORMS\MEDSHEET

PATIENT: Dan McCormack

MEDICATION / MG	SIG	Start	Refill Dates --Quantities--Initials					
Diltiazem 300mg	1 q AM		5-28-03 #7 G4/AR	5-28-03 #90X3 G4/AR	11/25/03 #90X3 G4/AR			
Diltiazem 180mg	1 q pm		5-28-03 #90X3 G4/AR	~~11/25/03~~ 11/25/03 #90 ~~G4/AR~~				
Lanoxin 0.25mg	1 bid		5-28-03 #14 G4/AR	11/25/03 #180X3 G4/AR				
Allopurinol 100mg	iii qd							
Zantac 300mg	q pm	6-24-03 #30X1year G4/AR	D/C					
ASA 325 q DAY								
Protonix 40mg	qd							

Allergies: Sulfa, Ampacillin, Septra

ERNST AND MATTISON
A LAW CORPORATION
1020 Palm Street
P. O. Box 1327
San Luis Obispo, CA 93406
Tel: (805) 541-0300
Fax: (805) 541-5168

DON A. ERNST
RAYMOND E. MATTISON

FOUNDED 1980

CHRISTOPHER J. EDGINGTON
NIGEL A. WHITEHEAD
TERRY J. KILPATRICK

FAX TRANSMITTAL

FAX No: (805) 434-2019

TO: Dr. Gordon Lemm

FROM: Don A. Ernst
Ernst and Mattison

DATE: October 1, 2009

RE: **Daniel McCornack**

DOCUMENTS	NUMBER OF PAGES
Santa Cruz County Coroner's report; copy of May 2, 2008 recall letter from Caremark	12

COMMENTS:

Please see attached.

6-3

Sheriff-Coroner
Santa Cruz County
State of California

DEATH INVESTIGATION
REPORT
Case Number: 08-02797

NAME:	MCCORNACK, Daniel Elwin	**DATE OF BIRTH:**	2/15/1963
RESIDENCE:	6255 Peachy Canyon Paso Robles CA 93446	**AGE:**	45 Years
NEXT OF KIN:	Kathy McCornack (Wife)	**BIRTH PLACE:**	CA
ADDRESS:	6255 Peachy Canyon Paso Robles CA 93446	**GENDER:**	Male
NOTIFIED BY:	Naomi Silva	**RACE:**	Caucasian
IDENTIFIED BY:	In Person	**MARITAL STATUS:**	Married
LOCATION OF DEATH:	Private Camp Ground	**OCCUPATION:**	Plant Manager
MANNER OF DEATH:	Natural	**DEATH DATE:**	03/23/2008
CAUSE OF DEATH:	Cardiac Arrest	**DEATH TIME:**	00:52:00
DUE TO:	Ventricular Arrhymia	**AUTOPSY:**	Yes
DUE TO:	Atrial Fibrillation	**INVESTIGATOR:**	Naomi Silva
DUE TO:	Hypertensive and Arteriosclerotic Cardiovascular Disease	**FUNERAL HOME:**	Kuehl-Nicolay Funeral and Cremation
OTHER SIGNIFICANT CONDITIONS:	Exogenous Obesity	**PROPERTY:**	None

SUMMARY OF INVESTIGATION

On Sunday, March 23, 2008 at approximately 0114 hours, I was notified by Net-Com of a death at 4770 Hwy 9, Felton. I was advised by dispatch that Deputy Ryan was on scene and was requesting my response. Prior to arrival I contacted Deputy Ryan by telephone and he briefed me of the circumstances.

Deputy Ryan advised that decedent, Daniel McCornack, is a 45 year old male who resides in Paso Robles. He was on Easter holiday with his immediate and extended family at Smith Woods RV Park in Felton. According to Kathy McCornack, the decedent's wife, they went to bed at approximately 2200 hours. At approximately 0030 hours she attempted to wake her husband up because she thought he was snoring. When she turned the lights on she noticed his face was discolored. She called "911", and emergency crews responded. They attempted heroics, but were unsuccessful, and pronounced him dead at 0052 hours.

Upon arrival I contacted Dep. Ryan who escorted me to the Recreational Vehicle (RV) where Kathy McCornack was waiting, he then pointed out the RV where the decedent was. I introduced myself to Kathy McCornack who was visibly upset. She was sitting with her two teen age sons and her father in law. I introduced myself, offered my condolences, and asked her to describe what had happened.

Kathy McCornack said they had driven out to Smith Woods RV Park, from their home in Paso Robles. She explained that her family, along with their extended family, spends their Easter holidays together.

8/26/08

Signature: Naomi Silva 3/20/2008 6-4
Naomi Silva, Deputy Coroner
Date 4.5.12/2011

Sheriff-Coroner
Santa Cruz County
State of California

DEATH INVESTIGATION
REPORT
Case Number: 08-02797

They arrived mid-day and set up camp, had dinner and settled around the camp fire. Kathy said her husband, Daniel, had a full day but never complained of being in any discomfort or pain. She informed me that he has had an irregular heart beat for many years, and was on heart medication. She did not have the prescription bottles with her, but provided me with his weekly pill/vitamin organizer.

At approximately 2200 hours Kathy McCornack and her husband went to bed. Kathy said that they were woken at 0030 hours by their two teen-age sons. They had entered their RV from the family camp fire. Kathy said that at approximately 0030 hours she heard her husband making a strange noise in bed. She shook him and told him he was snoring. The noise continued so she turned the light on and noticed his face was discolored. She woke her sons and called "911". She said that she attempted Cardio Pulmonary Resuscitation (CPR), but described only compression to his chest.

I left Kathy McCornack with her family and went to investigate the decedent in a nearby RV. I observed the decedent lying in a supine position on the floor of the large RV. The decedent had been moved from the bedroom to the common area of the RV. The decedent had two defibrillator electrodes attached to the skin of his chest, and an intravenous line in place on the top of his left hand. The decedent was clad in men's briefs. Postmortem rigor mortis was beginning to set in the decedent's jaw and extremities. There was no evidence of struggle or foul play. I did not observe any trauma to the external portion of the decedent's body.

I transported the decedent to the Sheriff-Coroner's Medical Facility where he was placed on a tray and fitted with an identification bracelet and tray tag. I was able to obtain limited medical records for the decedent, which I provided to Dr. Richard T. Mason for his review. All of the decedent's medications were collected and counted. It is unknown it his prescribed medication was being taken as prescribed since they were not in their respective containers.

Dr. Richard T. Mason, a Forensic Pathologist, performed an autopsy on 03/26/2008 at approximately 0730 hours. Dr. Mason determined the cause of death to a cardiac arrest due to ventricular arrhythmia due to, atrial fibrillation, due to hypertensive and arteriosclerotic cardiovascular disease, with contributory causes of exogenous obesity. During the examination, Dr. Mason collected post mortem cardiac blood, urine and liver tissue specimens for toxicological testing at the National Medical Services Laboratory. Dave Cutter, Forensic Technician, sent the listed items to the National Medical Services Laboratory on March 27, 2008 via Federal Express. On April 21, 2008 this Office received the Toxicology Reports regarding decedent Daniel McCornack. On May 2nd, 2008, Dr. Richard Mason requested an additional test be run for the drug Digoxin. The blood sample for this test was already in the possession of the National Medical services Laboratory. This Office received the results for the subsequent test on June 27, 2008. Refer to the attached Toxicology Reports for detailed test results.

Signature: N Silva 13/10985
Naomi Silva, Deputy Coroner

DNA 4.5.12/051112

6-5

Sheriff-Coroner
Santa Cruz County
State of California

DEATH INVESTIGATION
REPORT
Case Number: 08-02797

CONCLUSION:

Based on my investigation and information obtained from the autopsy examination, it is the opinion of this Office that Daniel McCornack succumbed to natural causes.

Signature: N Silva 12/10/0935
Naomi Silva, Deputy Coroner

DA 7.55/08/11 77
6-6

SANTA CRUZ COUNTY SHERIFF-CORONER'S OFFICE
701 Ocean Street
Santa Cruz, California
* REPORT OF AUTOPSY EXAMINATION *

AUTOPSY NUMBER: CA08-037 **FILE NUMBER:** 08-02790

NAME: Daniel Mc Cornack **AGE:** 45 **SEX:** Male

PLACE OF DEATH: Smithwood R.V. Park, 4770 Hwy 9, Felton

DATE/HOUR OF DEATH: March 23, 2008 @ 0052 Hours

AUTOPSY PERFORMED: Santa Cruz County Morgue

DATE/HOUR OF AUTOPSY: March 26, 2008 @ 7:30 a.m.

PATHOLOGIST: Richard T. Mason, M.D.

BODY IDENTIFIED BY: Ankle tag.

ATTENDING PHYSICIAN: None.

CAUSE OF DEATH: CARDIAC ARREST
Due to: Ventricular arrhythmia
Due to: Atrial fibrillation
Due to: Hypertensive and arteriosclerotic cardiovascular disease.

CONTRIBUTORY: Exogenous obesity.

MANNER: Natural.

DIAGNOSES:

1. Hypertensive and arteriosclerotic cardiovascular disease with:

6-7

DIAGNOSES, continued

A. Cardiomegaly and left ventricular hypertrophy.
B. Coronary arteriosclerosis, mild to moderate.
C. Myocardial fibrosis, mild.
D. Atrial fibrillation by history.
E. Probable ventricular arrhythmia and arrest.

2. Cerebral edema and congestion.

3. Pulmonary edema and congestion.

4. Exogenous obesity, moderate.

RICHARD T. MASON, M.D.
Forensic Pathologist

RTM/dp

6-8

EXTERNAL EXAMINATION

The body examined is that of a well-developed, mildly obese, middle-aged white male that appears the stated age of 45 years. The body is 70 inches in length and weighs 220 pounds. The scalp hair is medium brown with gray and is cut short measuring 1/4 inch. The eyes are blue gray with the pupils equal in diameter, measuring 6 mm. There is an adhesive nostril dilating device attached over the midportion of the nostrils. There is a short 3/4 inch grayish brown mustache. Natural teeth in good condition are present in the mouth. There is a 1-2 mm growth of beard present on the lower face. There is prominent pinkish cyanosis of the anterior face and neck.

Examination of the anterior chest reveals 4 x 6 inch adhesive defibrillator electrodes present over the left lower lateral chest and the right upper anterior chest. Adhesive EKG electrodes are present over the right and left upper anterior chest and the right and left lower abdomen. The axillae are normal.

Examination of the anterior abdomen reveals it to be mildly obese. There is a slight umbilical hernia. There are no other marks or wounds are noted on the anterior abdomen. Normal male external genitalia are present. The penis is circumcised.

Examination of the lower limbs reveals normal, symmetric, muscular right and left thighs and right and left lower legs. There is a coroner's identification band present on the right ankle bearing the name: McCornack, Daniel; #08-2790. The right and left feet are normal.

Examination of the upper limbs reveals normal, symmetric, muscular right and left upper arms and right and left forearms.

The antecubital spaces are clean with no marks or wounds. The right and left forearms are unremarkable. An intravenous line is in position through a needle puncture wound on the dorsum of the left hand. This line is attached to a 1-liter bag of normal saline.

Examination of the hands reveals them to be normal with short intact fingernails.

INTERNAL EXAMINATION

HEAD:
Reflection of the scalp reveals an absence of any contusions on the galeal surface. The calvarium is intact. Reflection of the calvarium reveals prominent cerebral edema. The gyri are flattened. The meninges are clear but congested. The brain weighs 1,640 grams. The brain has a normal external morphology except for the edema. The cerebral arteries are normal in distribution and appearance.

Multiple coronal sections through both cerebral hemispheres reveal normal cortex, normal white matter and normal basal ganglia. Sections through the brainstem and cerebellum reveal these structures to be normal.

The dura is stripped from the base of the skull to reveal an intact skull base.

NECK:
The hyoid bone, larynx, trachea, soft tissues, cervical spine are intact. The airway is fully patent.

BODY CAVITIES:
The pericardial cavity contains 25 mL of clear yellow fluid. There is no excess fluid in the pleural or peritoneal cavities.

CARDIOVASCULAR SYSTEM:
Heart weight 500 grams. There is cardiomegaly and left ventricular hypertrophy. The epicardial surfaces are smooth and glistening. The heart valves are normal. The atria are normal in size. The endocardial surfaces of the atria and ventricles are normal in appearance. Dissection of the coronary arteries reveals abundant, scattered, flattened atherosclerotic plaque in the right coronary artery, which is of greatest circumference compared to the LAD and the circumflex coronary arteries. There is flattened atherosclerotic plaque in a small left anterior descending coronary artery. There is a minimal amount of atherosclerotic plaque in the left circumflex coronary artery. Multiple cross sections through both ventricles of the heart reveal some mild diffusely distributed myocardial fibrosis. There is cardiomegaly and left ventricular hypertrophy with the left ventricle measuring 16 mm in thickness and the right ventricle measuring 4 mm in thickness. There are no foci or evidence of old or recent myocardial infarction.

Examination of the aorta reveals it to be smooth with minimal focal atherosclerosis. The superior and inferior vena cavae are intact and normal with no thromboemboli.

RESPIRATORY TRACT:
Lungs, weight right 830 grams, left 840 grams. There is severe bilateral pulmonary edema and congestion. Bloodstained watery fluid runs from the cut surfaces of all lobes of both lungs. There are no foci of consolidation. The major bronchi contain a small amount of bloodstained edema fluid. The pulmonary arteries are widely patent with no thromboemboli.

LIVER:
Weight 2,550 grams. The smooth, light, reddish tan capsular surface is intact. The liver is enlarged and there is fatty metamorphosis. The parenchyma is light pinkish tan and fractures easily on digital pressure. There is no increase in fibrous tissues to palpation. The intra and extrahepatic blood vessels and bile ducts are grossly normal. The gallbladder is thin-walled and contains 1 mL of light brown transparent bile.

SPLEEN:
Weight 470 grams. This organ is enlarged and congested. The dark gray brown capsular surface is intact with no evidence of trauma. The parenchyma is dark red brown firm.

PANCREAS:
Weight 210 grams. Normal, pale tan, lobular, autolyzed parenchyma is noted on cut section.

ENDOCRINE SYSTEM:
The pituitary, adrenal and thyroid glands are grossly normal.

GENITOURINARY TRACT:
Kidneys, weight right 230 grams, left 220 grams. The cortical surfaces of both kidneys are smooth, dark red,

congested. Normal corticomedullary markings are noted on sagittal section. The calyces, pelves, ureters are normal. The urinary bladder contains 200 mL of clear yellow urine. The prostate and seminal vesicles are normal. The testes are normal to palpation. A normal circumcised penis is present.

GASTROINTESTINAL TRACT:
The esophageal mucosa is autolyzed. The gastric mucosa is autolyzed. The stomach contains 1130 grams of viscous, masticated, pale tan food material containing fragments of vegetable material and meat. The small and large bowel are grossly normal. The vermiform appendix is present and normal.

MUSCULOSKELETAL SYSTEM:
The musculoskeletal system normal. There is exogenous obesity and the abdominal panus is 4.5 cm in thickness.

URINE DRUG SCREEN:
Medtox Immunochromatographic plate

THC:	Negative.
Opiates:	Negative.
Amphetamines:	Negative.
Cocaine:	Negative.
PCP:	Negative.

CVS CAREMARK | CAREMARK

May 2, 2008

Daniel McCornack
6255 Peachy Canyon Rd
Paso Robles, CA 93446-7680

Dear Plan Participant:

CVS Caremark is committed to your safety and to providing you with important news about your medicines. As part of this commitment, we are sending you information that may be valuable to you.

On April 25, 2008, Actavis Totowa® LLC, the manufacturer of Digitek® 0.125 mg and Digitek 0.25 mg tablets, issued a Patient Level Recall of all lots of these products as a precaution **because the tablets may be double the appropriate thickness and could contain twice the approved level of active ingredient.** Because of this, the manufacturer is recalling all lots of these products.

Actavis manufactures the products for Mylan and the products are distributed by Mylan and UDL under the Bertek and UDL labels. Bertek and UDL are affiliates of Mylan.

This recall only affects Digitek 0.125 mg and Digitek 0.25 mg Mylan and UDL under the Bertek and UDL labels. No other digoxin products are affected by this issue.

If you filled a prescription for Digitek 0.125 mg or Digitek 0.25 mg tablets between **January 28, 2008** and **April 28, 2008,** we will be sending replacement product to you that is not affected by this recall at no cost to you. You will also receive instructions on how to return your remaining Digitek.

If you have product on hand from an order before **January 28, 2008,** please contact our Customer Care department, toll-free at **1-800-966-5772.**

Please do not stop your digoxin therapy without talking to your doctor. Stopping digoxin therapy suddenly can cause serious health problems. Please contact your doctor to obtain a new prescription for a short term retail supply if necessary.

For more information on this issue you may contact the U.S. Food and Drug Administration (FDA) consumer inquiry line toll-free at 1-888-INFO-FDA (1-888-463-6332) or by accessing the FDA Web site at www.fda.gov.

If you have questions regarding your prescription coverage, please contact a Customer Care representative toll-free at the Customer Care number listed on your benefit ID card or in your Welcome Kit. You can reach us 24 hours a day, seven days a week. You may also access our Web site at www.caremark.com. If you have a hearing impairment and need telecommunications device (TDD) assistance, please dial the toll-free TDD number located on your benefit ID card.

We are dedicated to plan participant safety and look forward to your continued participation in the Caremark Mail Service Pharmacy program.

Sincerely,

Jan Berger MD MJ

Jan Berger, MD, MJ
SVP, Chief Clinical Officer
Medical Affairs
CVS Caremark

105-14158k 43311-332313100

Gordon D. Lemm M.D. *Hendrik F. Breytenbach M.D.*

PATIENT INFORMATION

Patient Name Dan McCormick **Sex** M / F **Date of Birth** 2/15/63

Telephone # Home ( ) 238-5208 **Cell** ( ) 441-4257 **Office** ( ) 226-3132

Mailing Address 6255 Peachy Cyn. Rd. **SS#** 555-51-7837

City Paso Robles **State** CA **Zip Code** 93446

Street Address *(Only if different from the above address)* ———

Emergency Contact Kathy McCormick **Tel#** ( ) 610-0750 **Relationship** Wife

Patient Employer Information

Employer Name Lubrizol Tel# 239-1550

Street Address 3115 Propeller Dr. City/State Paso Robles Zip 93446

Occupation Plant Manager

PRIMARY Insurance Information (If Incomplete/Invalid you will be responsible for payment)

Insurance Company Name Health Design Plus

Effective Date 4/02 ID# 102748 Group# LU1

*****Name of person who provides the insurance coverage**Policy Holder (If not patient)***

Name of Insured Patient SS# Birthdate

Relationship to patient Employer

SECONDARY Insurance Information (If Incomplete/Invalid you will be responsible for payment)

Insurance Company Name ———

Effective Date ID# Group#

*****Name of person who provides the insurance coverage**Policy Holder (If not patient)***

Name of Insured ——— SS# Birthdate

Relationship to patient Employer

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim.
I permit a copy of this authorization to be used in place of the original.

I hereby authorize Dr. Lemm and/or Breytenbach to apply for benefits on my behalf for covered services ~~rendered by him, or by his order. I request payment from my insurance company~~ be made directly to Dr.Lemm / Breytenbach (or to the party who accepts assignment). This authorization may be revoked by either me or my insurance company at any time in writing.

I certify that the information I have provided is true and correct.

Signature Dan McCormick **Date** 11/8/08

RECEIPT OF NOTICE PRI .CY PRACTICES WRITTEN ACKI VLEDGEMENT FORM

Patient' s Name: Dan McConnack SR

Patient's Date of Birth: 2/15/63 Patient's SSN: 555-51-7837

I give my permission to discuss medical information with the following family members or designated persons. I understand that due to HIPPA guidelines, medical information will only be discussed with me and those listed below. Medical information may include but is not limited to appointments, prescriptions, and test results.

1. Kathy McConnack DOB 9/7/66 RELATIONSHIP wife TEL.# 238-5208
2. _____ DOB _____ RELATIONSHIP _____ TEL.# _____
3. _____ DOB _____ RELATIONSHIP _____ TEL# _____

	Circle One
I give permission to have telephone messages left on my answering machine.	(YES) NO
I give permission to send written communication to my home address.	(YES) NO
I give permission to leave messages / call back number at my work Telephone number.	(YES) NO
I give permission to send written communication to my work or office.	YES (NO)

Notice to Patient: By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information. As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer. You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you. You are entitled to a copy of this **Consent Form** after you have signed it.

This authorization will be in effect until it has been revoked in writing.

(To Be Completed by Patient or Patient's Representative)

I, Dan McConnack SR, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Dan McConnack — Patient's Signature or Signature of Patient's Representative

8/16/04 7/25/06 3/2/07 (VSM) 1/8/08 (DM) — Date

Printed Name of Patient's Representative

Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: TERI LEMM
Practice Address: 292 Posada Lane Ste. D. Templeton, Ca. 93465
Phone: 805 434-3211
Fax: 805 434-2019

HIPPA Consent for Use / Disclosure of Health Information
This form does not constitute legal advice and covers only federal, not state, laws.

LUBRIZOL PPO
Group Number: LU1

Lubrizol

HEALTH DESIGN PLUS

Participant Name: DANIEL MCCORNACK

Participant ID Number: 1027478

1715

For questions regarding your medical eligibility, benefits or claims, call Health Design Plus at **1-800-893-0777** or visit www.hdplus.com for member online services

To verify a network provider, call First Health at **1-800-226-5116** or visit their website at www myfirsthealth.com

First Health Network

Cancer Manager Program™

For Pre-Certification:

Your Plan may require pre-certification for certain treatments and procedures
Refer to your Summary Plan Description (Resource Guide) for plan specifics

To certify medical services, call Health Design Plus at **1-888-4MEDREP**

Call **Behavioral Health Systems** at **1-800-245-1150**
to pre-certify or ask questions regarding mental health/substance abuse coverage and claims

BHS
BEHAVIORAL HEALTH SYSTEMS

For Providers Only:
Submit all medical claims via electronic submission in HCFA 1500/UB 92 format to:
EDI number – 34158
Or submit paper claims in current standardized format to:
Health Design Plus
P.O. Box 2581
Hudson, OH 44236-2581
To verify medical eligibility, benefits or claims, call Health Design Plus at **1-800-893-0777**.

This card is for identification purposes only and does not guarantee coverage. 1-08

JAN 0 8 2008

6-17

Gordon D. Lemm M.D. **Hendrik F. Breytenbach M.D.**

OFFICE POLICY AND PROCEDURES

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and understanding of our office policies and procedures.

Primary Insurance
We will bill your **PRIMARY** insurance as a courtesy to you.
A current insurance card **must** be provided at the beginning of **each** visit. Payment will be expected at the time of service if eligibility cannot be verified.

Secondary Insurance
We **do not** submit claims to secondary insurances **UNLESS** the secondary is an HMO or Medicare.

Insurance Benefits
Please contact your insurance company prior to services being rendered to see if they will be covered under your policy, especially when they are preventive visits or procedures.

Medicare Patients
A telephone call to your secondary/supplemental insurance company will confirm that Medicare claims are automatically transferred for processing.
You will receive a statement from our office if payment from your supplemental insurance is not received within approximately 30 days of Medicare's payment.

Payments
Co-pays, co-insurance, and deductible amounts are **due at the time of service**.
Patients without insurance are expected to pay in full at the time of service.

We accept cash, checks, VISA, MasterCard,American Express, Discover and debit cards with the Visa or MasterCard logo.
We realize financial circumstances or situations may affect timely payment. In such situations, please call our office so we may assist you in making payment arrangements to keep your account in good standing.

Third Party Liability
If your visit is a result of a Third Party Accident you will be expected to pay the full charges and may seek reimbursement from the third party yourself.

Workers Compensation
We do not see patients for work related illness or injury.

Appointments:
A $25.00 charge may be applied for missed appointments and for appointments canceled with less than 24 hour advance notice. If a patient repeatedly misses or cancels an appointment, the patient may be dismissed from the practice.

6-18

Returned Checks:
All returned checks are subject to a $25.00 non-sufficient funds (NSF) fee.

Collection Procedures:
We reserve the right to forward any past due balance(s) to a third party for collection purposes.

Form Fee:
There will be an additional $25.00 fee for the filling out of forms including but not limited to: all DMV forms, disability, Residential Care Facility Exam (RCFE) and CMN.

Medication Refills Policy:
Please allow 48 hours for refill requests to be processed. If you already have an existing prescription, please call your local pharmacy and ask them to fax a refill request to our office.
On Friday's to assist you better, please make sure requests are in by **10:00AM**. The doctor is only here till noon on this day.

We reserve the right to dismiss any patient from this practice at the doctor's discretion.

Please do not hesitate to ask us if any of the above information is unclear.

I acknowledge and understand the office policies and procedures explained above.

Patient Name **(print)** Dan McCormack

Signature of Patient _____ Date 11/8/08

Patient received a copy *Yes* ____ *No* X

Required if the patient is a minor or adult who is unable to sign this form

Patient Representative Name **(print)** _____

Signature of Representative _____

Relationship of Patient Representative to the Patient _____

Date _____

We sincerely appreciate your cooperation.

Dr. Gordon D. Lemm M.D. and Dr. Hendrik F. Breytenbach M.D.

6-19

Gordon D. Lemm M.D. *Hendrik F. Breytenbach M.D.*

PATIENT INFORMATION

Patient Name Dan McCornack SR. Sex (M) F Date of Birth 2/15/63

Mailing Address 6255 Peachy Cyn. Rd. SS# 555-51-7837

City Paso Robles State CA Zip Code 93446

Telephone # Home (805) 238-5208 Cell (805) 441-4257 Office (805) 226-3132

Emergency Contact Kathy McCornack Tel# (805) 2385208 Relationship wife

Street Address (only if different from above) _____

City _____ State _____ Zip Code _____

Patient Employer Information

Employer Name Lubrizol Tel# 805-239-1550

Street Address 3115 Propeller DR. City/State CA Zip 93446

Occupation Plant Manager

Insured Person (This is mandatory information if the patient is NOT the insurance holder)

Name of Insured _____ SS# _____ Birthdate _____

Relationship to patient _____ Employer _____

Insurance Information

Insurance Company Name Health Design Plus

Effective Date _____ ID# 1027478 Group# LU1

INFORMATION AND ASSIGNEMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim.
I permit a copy of this authorization to be used in place of the original.

I hereby authorize Dr. Lemm / Breytenbach to apply for benefits on my behalf for covered services rendered by him, or by his order. I request payment from my insurance company be made directly to Dr.Lemm / Breytenbach (or to the party who accepts assignment). This authorization may be revoked by either me or my insurance company at any time in writing.

I certify that the information I have reported is true and correct.

Signature _____ Date 3/2/07

620

LUBRIZOL PPO
Group Number: LU1

LUBRIZOL

HEALTH DESIGN PLUS

Participant Name: DANIEL MCCORNACK

Participant ID Number: 1027478

1787

For questions regarding your eligibility, benefits or claims, call Health Design Plus at 1-800-893-0777 or visit us at www.hdplus.com for our plan member online services.

To verify a network provider, call First Health at **1-800-226-5116** or visit their website at www.myfirsthealth.com

First Health Network

Cancer Manager Program™

For Pre-Certification:

Your Plan may require pre-certification for certain treatments and procedures. Refer to your Summary Plan Description (SPD) for plan specifics

To certify medical services, call Health Design Plus at **1-888-4MEDREP**.

Call **Behavioral Health Systems** at **1-800-245-1150** for questions or to pre-certify mental health/substance abuse coverage

BHS
BEHAVIORAL HEALTH SYSTEMS

For Providers Only:

Submit electronic claims using Electronic Data Interchange (EDI) to: #34158

Health Design Plus strongly encourages providers to submit claims electronically to expedite processing.

OR

Health Design Plus
P.O. Box 2581
Hudson, OH 44236-2581

Providers: To verify eligibility, benefits or claims, call Health Design Plus at **1-800-893-0777**.

This card is for identification purposes only and does not guarantee coverage. 1-07

MAR 0 2 2007

621

SANTA CRUZ COUNTY SHERIFF-CORONER
Steve Robbins, Sheriff-Coroner
701 Ocean St. Room 340
Santa Cruz, CA 95060

SANTA CRUZ COUNTY SHERIFF-CORONER

Investigation Division

Facsimile Transmittal Form

To :	Voice Line: (805) 434-3211
Dr Lem's Office, **Arlene in Medical Records**	Fax Line: (805) 434-2019

From:	Naomi Silva Deputy Coroner Investigations Division; Coroner's Section Voice Line: (831) 454-2520 Fax Line: (831) 454-3553

Number of Pages (Including Cover) __1_____

Urgent **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments: We are investigating the death of Daniel Mc Cormack, DOB of 02/15/1963. He passed away on 03/23/2008. We are requesting any medical records you have regarding the care and treatment she received. As always if there are a large amount of records, we are mainly after the physical history statements. Call me if there are lots of records, and someone from our office with come pick them up. Thank you. Naomi Silva**

Records faxed 3-24-08
10:50 ab

6-22

08/13/2009 23:25 7146 791 EZ COPY PAGE 02

DEPONENT: DR. GORDON LEMM (TAG 1)
RECORDS PERTAIN TO: DANIEL E. MCCORNACK, SR
RECORDTRAK FILE #: 196975 DATE OF BIRTH: 02/15/1963 SOCIAL SECURITY #: ###-##-7837
RECORD IDENTITY:

DGT.CG01

196975.1

1. ALL MEDICAL RECORDS IN YOUR POSSESSION. INCLUDE OFFICE AND HAND WRITTEN NOTES, TEST RESULTS, CORRESPONDENCE, QUESTIONNAIRES/HISTORY & RECORDS RECEIVED BY OTHER PHYSICIANS. PLEASE ALSO INCLUDE THE PATIENTS INFORMATION SHEET.PLEASE BE SURE TO INCLUDE ALL ARCHIVED RECORDS AND ALL RECORDS LOCATED IN STORAGE.2. SIGNED CERTIFICATION PAGE IS REQUIRED.

SECTION I CERTIFICATION OF CUSTODIAN OF RECORDS

I, the undersigned, being the duly authorized custodian of records or other qualified witness, and having the authority to certify the attached records declare the following: the attached records (1) were made at or near the time of the act, event, condition, opinion or diagnosis by a person with knowledge of the matters reflected in the records; (2) were kept in the course of regularly conducted activity; and (3) were created as part of the regular practice of the provider, and that:

A – X page(s) of the original records described was made available to the attorney's representative for copying at our place of business.
B – a true, legible and durable copy of _____ pages of the described records was delivered to the attorney's representative.

I DECLARE, UNDER PENALTY OF PERJURY, THAT THE FOREGOING IS TRUE AND CORRECT.

Executed on (date) 8/18/09 at (city,state) Templeton CA

Signature Arleen Buzzelli Print Name Arleen Buzzelli

Phone Number _____ Department _____

E-mail Address to Forward Requests for Production of Records/Materials: _____

SECTION II CERTIFICATION OF NO RECORDS

A thorough search of our files, carried out under my direction revealed no documents, records or other materials called for in the subpoena or authorization, for the following reason:

- ☐ All records for the time period in question have been destroyed in accordance with our document retention policy which is ___ years.
- ☐ Our records are the same as _____.
- ☐ Original records are in the possession of _____.
- ☐ (other) _____.

I DECLARE, UNDER PENALTY OF PERJURY, THAT THE FOREGOING IS TRUE AND CORRECT.

Executed on (date) _____ at (city,state) _____

Signature _____ Print Name _____

Phone Number _____ Department _____

E-mail Address to Forward Requests for Production of Records/Materials: _____

THIS PAGE MUST BE COMPLETED, SIGNED AND RETURNED.

RECORDS

~~Faxed~~ Jail Counties Legal Docs
copied 8-19-09
ab

6-23

RECORDTRAK
THE TRACK RECORD OF SUCCESS

196975.1

DGT.CG01

651 Allendale Road
P. O. Box 61591
King of Prussia, PA 19406
Phone: (800) 220-1291
Fax: (610) 354-8946

August 7, 2009

Re: **DANIEL E. MCCORNACK, SR**

MEDICAL RECORDS
DR. GORDON LEMM
292 POSADA LANE
SUITE D
TEMPLETON CA 93465

SS #: ###-##-7837
DOB. 02/15/1963 DOD: 03/23/2008
RT FILE #: 196975 TAG #: 1

Dear Record Custodian:

Attached is **an authorization** requiring you to furnish *RECORDTRAK* with the following materials on or before August 17, 2009:

1. **ALL MEDICAL RECORDS IN YOUR POSSESSION. INCLUDE OFFICE AND HAND WRITTEN NOTES, TEST RESULTS, CORRESPONDENCE, QUESTIONNAIRES/HISTORY & RECORDS RECEIVED BY OTHER PHYSICIANS. PLEASE ALSO INCLUDE THE PATIENTS INFORMATION SHEET.PLEASE BE SURE TO INCLUDE ALL ARCHIVED RECORDS AND ALL RECORDS LOCATED IN STORAGE.**
2. **SIGNED CERTIFICATION PAGE IS REQUIRED.**

Please fax responses along with our request and certifications to RecordTrak at the fax number listed above. If the records are too voluminous to fax, please provide them on CD or mail paper copies to the address listed above.

Before copying and/or invoicing, call or fax *RECORDTRAK* with a page count and pricing for approval. Please include your federal tax id number on all invoices. Refer to File # 196975 Tag 1 in any correspondence.

Very Truly Yours,

RecordTrak Representative
Phone: (800) 220-1291

IMPORTANT:
*****RESPONSES WILL NOT BE ACCEPTED WITHOUT COMPLETED AND SIGNED CERTIFICATION(S).*****

6-24

To: DR. GORDON LEMM
292 POSADA LANE
SUITE D
TtempleTON, CA 93465

RECORDTRAK
651 Allendale Road
P. O. Box 61591
King of Prussia, PA 19406

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION PURSUANT TO 45 C.F.R. 164.508

Patient Name: Daniel E. McCornack, Sr.

Identification: Date of Birth 2/15/53 Date of Death 3/23/08 Soc. Sec. 555-51-7637
Parents Name/Previous Name(s)

Provider: *(Who is releasing the information)* DR. GORDON LEMM

Requestor: *(to whom the information will be provided)* Name RecordTrak
Address 651 Allendale Road
King of Prussia, PA 19406

Information Requested: I authorize the disclosure of all protected medical information, from the time period 1998 to present, in written or electronic form for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and completed protected health information, including, but not limited to, the following:

- All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or health care providers;
- All laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports,
- All radiology films; myelograms; CT Scans; photographs; bone scans; pathology, cytology, histology, autopsy, immunohisto chemistry specimens;
- All pharmacy prescription records, including, but not limited to: NDC numbers and drug information handouts/monographs
- All billing records, including, but not limited to: all statements, itemized bills, and insurance records.
- All documents related to amendment of any record requested.

Purpose of Release: For the purpose of review and evaluation in connection with a legal claim.

This authorization expires when the following event occurs: the resolution of litigation. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to RecordTrak. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information would no longer be protected by the federal privacy rule. Any facsimile, copy or photocopy of this authorization authorizes you to release the records requested herein.

Signature of Patient if 18 years of age or older Kathy McCornack Date 7/29/2009

Signature of Parent or Legal Representative _____ Date _____

Relationship to Patient, if not signed by Patient Wife of Daniel E. McCornack, deceased

SPECIFIC authorization for release of information protected by state or federal law In addition to the authorization and other provisions contained above, **hereby incorporated by reference, I authorize: (i) the release of data and information to RecordTrak; and (ii) RecordTrak's re-disclosure of the data and information to its consultants, experts, agents, and/or other counsel; any and all data, notes, records, reports, and/or any other documents and information relating to:**

X 1. Substance Abuse (Alcohol/Drug) X 2. Mental Health (includes psychological testing) X 3. HIV-related information (AIDS related testing)

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5000 in the case of each subsequent offense. Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175); Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

Signature of Patient if 18 years of age or older _____ Date _____

Signature of Parent or Legal Representative _____ Date _____

Relationship to Patient, if not signed by Patient _____

6-25

URGENT REQUEST FROM RECORDTRAK

Date: August 7, 2009

MEDICAL RECORDS
DR. GORDON LEMM
292 Posada Lane Suite D
Templeton CA 93465

TO:	**DR. GORDON LEMM**
ATTN:	
FAX #:	**1(805)434-2019**
PAGES:	
FROM:	**RecordTrak Representative**
RE:	**DANIEL E MCCORNACK. SR**
RT #:	**196975** Tag #: **1**

Message:

ANY QUESTIONS OR PROBLEMS PLEASE CALL

Phone : (800) 220-1291
Llamadas en español, marque (800) 496-4788
Fax# (610) 354-8946

6-26

02744-02

ADVANCED LEGAL SERVICES

1026 Palm Street, Suite 202
San Luis Obispo, CA 93401
Phone: (805)542-0511 | Fax: (805)542-0512

May 28, 2008

Custodian of Records
Gordon Lemm, M.D.
292 Posada Lane, Suite D
Templeton, CA 93465

Dear Custodian of Records,

Advanced Legal Services has been employed by Ernst & Mattison to obtain records regarding the patient listed below. Attached please find an Authorization for Release of Medical Information on the following individual:

Records Of:	**Daniel Elwin McCornack, Sr.**	Records Requested:
DOB:	**02/15/1963**	☒ **Medical Records**
SSN:	**XXX-XX-7837**	☒ **Radiology**
		☒ **Billing**

Please contact our office when records are ready to be copied. Our onsite service is available to copy requested records at your place of business during normal business hours.

Or you may mail the records requested to our office at the following address:

Advanced Legal Services
1026 Palm Street, Suite 202
San Luis Obispo, CA 93401

If any additional fees are required, please call our office before copying records.

If you have any questions regarding the production of business records, please contact our office at 805.542.0511.

Sincerely,

Advanced Legal Services

notified chart ready 6-6-08
ck recd
billing records ready
DONE

6-27

AUTHORIZATION TO RELEASE OR RECEIVE PROTECTED HEALTH CARE INFORMATION PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

Identification of Entities:

Records Subject: Daniel Elwin McCormack SR Date of Birth: 2·15·1963

Name of Requestor: ERNST and MATTISON Date of Injury: 3·23·2008

Name(s) of Provider(s): _____

Pursuant to the Health Insurance Portability and Accountability Act (HIPPA) privacy regulations, 45 C.F.R. § 164.508, the provider(s) listed above is/are hereby authorized to release to ERNST and MATTISON, or any of its agents or representatives, *all medical records, including but not limited to*: office notes, history, physical, consultation notes, discharge summary, medical reports, doctors' orders, progress notes, laboratory results, nurses' notes, emergency room records, operative records, inpatient records, outpatient records, records and films of x-rays, MRI, CAT scans, or other types of scans, pharmacy and drug records, medical bills, health insurance records, Medi-Caid, Medi-Care or Medi-Cal records, concerning any medical treatment of health care services that I have received from you, at your institution, as well as all such records which you keep in the regular course of business and are found in my medical file.

I hereby authorize release of all records regarding mental health or psychiatric treatment, chemical dependency or HIV records.

A photostatic copy of this authorization shall be as valid as the original.

The purpose of this authorization and request is to permit my attorneys to obtain ALL medical information pertaining to my physical and mental condition. This authorization expires two years from the date of the signature. The aforementioned expiration date has not passed as this matter is ongoing.

I have the right to revoke this authorization in writing by providing a signed, written notice of revocation of the health care provider(s) listed above and to ERNST and MATTISON. Medical providers may not condition treatment or payment on whether the above listed patient executes this authorization. The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPPA).

DATED: 5/20/08 Signed: Kathy McCormack

(Signature of Records Subject/Spouse/Parent Conservator/Guardian/Representative)

Wife of Daniel McCormack

Kathy McCormack

Type or Print Name

Witness: _____

AUTHORIZATION TO RECEIVE OR RELEASE CONFIDENTIAL INFORMATION

Identification of Entities:

Records Subject: Daniel Elwin McCormack SR. Date of Birth: 2·15·1963

Name of Requester: Ernst and Mattison Date of Injury: 3·23·2008

Name(s) of Provider(s): _____

Explanation:

This authorization to receive or release confidential information is to comply with the terms of the appropriate governing codes, including California Civil Code Section 56 et seq., California Evidence Code Section 1158, and others.

Authorization:

I, the undersigned, hereby authorize the Provider(s) named above to furnish to an agent, designee or representative of the Requester named above any and all records pertaining to medical history, services rendered or treatment given to Records Subject named above for the purpose of:
legal evaluation

Duration:

This authorization shall become effective immediately and shall remain in effect as long as necessary for Requester to fulfill the obligations required by the activities undertaken (not to exceed on year).

Restrictions:

I understand that the same restrictions for receipt or release of confidential information apply to Requester as to a Provider, and that no further authorization is made than is specifically indicated in this form.

Additional Copy:

I understand that a photocopy of this authorization is to be considered as valid as the original. I further understand that I have the right to receive a copy of this authorization upon my request.

Signature:

Date: 5/20/08 Signed: Kathy McCormack
(Signature of Records Subject/Spouse/parent/conservator/guardian/representative)
wife of Daniel McCormack
Kathy McCormack
Type or Print Name

Witness: _____

Le 29

GORDON D. LEMM, M.D.
292 POSADA LANE, SUITE D
TEMPLETON, CA 93465
(805) 434-3211 TEL.
DEA # AL 1051363
LIC. # G44422

NAME Dan McCormack AGE

ADDRESS DOB 2-15-63 DATE 10-14-04

Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

℞

Ref: Dr. Carr

Dx: L5 S disc protrusion

Refill _____ times

DO NOT SUBSTITUTE ☐

Gordon D. Lemm MD

To ensure brand name dispensing, check and initial box.

3LFP1132847

10-14-04
10-15-04

FAX COVER SHEET

Gordon D. Lemm, MD
phone (805)434-3211

Hendrik F. Breytenbach, MD
phone (805)434-3791

292 Posada Lane Suite D
Templeton, CA 93465
Fax (805)434-2019

Date: 8-26-04

Send to: Dr. Genovese Attn: _____

Fax number: 650-725-8418 Number of pages, including cover 5

Re: Dan McCormack

Comments: At request - see DS notes

Thank you

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

3/03

FAXED 8-26-04 MD

6-31

CENTRAL COAST GASTROENTEROLOGY
MEDICAL GROUP

Phillip M. Colbert, M.D., Inc.
77 Casa Street, Ste 108
San Luis Obispo, CA 93405
805/541-6080 FAX 541-0637
E-Mail: philcolbert@mac.com

Charles L. Fulbeck, M.D., Inc.
1551 Bishop Street, Ste 420
San Luis Obispo, CA 93401
805/549-9533 FAX 549-8001

Steven W. Carlson, M.D.
1551 Bishop Street, Ste 250
San Luis Obispo, CA 93401
805/543-8822 FAX 543-6221
E-Mail: scarlson5@aol.com

Gary L. Cushing, M.D.
1551 Bishop Street, Ste 510
San Luis Obispo, CA 93401
805/549-7843 FAX 549-9489

Jeffrey B. Mundorf, M.D., Inc.
1551 Bishop Street, Ste 230
San Luis Obispo, CA 93401
805/549-0784 FAX 786-4220

Vance D. Rodgers, M.D., Inc.
1551 Bishop Street, Ste 230
San Luis Obispo, CA 93401
805/786-4563 FAX 786-4220

Daniel C. Zovich, M.D., Inc.
234 Heather Court, Ste 101
Templeton, CA 93465
805/434-2434 FAX 434-5249

Paul D. Wetzel, M.D.
234 Heather Court, Ste 101
Templeton, CA 93465
805/434-5530 FAX 434-5249

North County Office
234 Heather Court, Ste 101
Templeton, CA 93465
805/434-0339 FAX 434-5249

South County Office
921 Oak Park, Ste 201
Pismo Beach, CA 93449

Board Certified:
American Board of Internal Medicine
American Board of Gastroenterology

August 23, 2004

TO: Gordon Lemm, MD
434-2019

FROM: Dan Zovich, MD
434-5249

RE: Dan McCornack

Since we are not providers for Mr. McCornack's CCN insurance, I have called and left a message for him to schedule with Dr. Colbert, Dr. Cushing, Dr. Carlson or Dr. Mundorf, who are contracted with CCN.

Thank you for your referrals.

Marie

Marie

FAX COVER SHEET

Gordon D. Lemm, MD
phone (805)434-3211

Hendrik F. Breytenbach, MD
phone (805)434-3791

292 Posada Lane Suite D
Templeton, CA 93465
Fax (805)434-2019

Date: 4-29-04

Send to: Phillip Colbert Attn: _____

Fax number: 541-0637 Number of pages, including cover 7

Re: Dan McCornack

Comments:

GI Ref - Colonoscopy

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

3/03

FAXED 4-29-04

FAX COVER SHEET

Gordon D. Lemm, MD
phone (805)434-3211

Hendrik F. Breytenbach, MD
phone (805)434-3791

292 Posada Lane Suite D
Templeton, CA 93465
Fax (805)434-2019

Date: 4-27-04

Send to: Dr. Zovich Attn: _____

Fax number: 434-5249 Number of pages, including cover 6

Re: Dan McCormack

Comments: GI ref - colonoscopy

The documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

3/03

4-27-04
mn

CaliforniaCare Directly Contracted Network in SLO County
Speedy Referral

Referral Number OTA

Patient Name: Dan McConnach	Birth Date: 2-15-63	Request Date: 1-28-02
PCP: G. Lemm	Patient Ph.# 238-5208	Certificate # : 555517837 (Auth expires in 90 Days)

Express Referrals to the Following Contracted Specialists Only:

✓ Cardiology	___ Neurology
___ Dermatology	___ O.B./Gyn.
___ Endocrinology	___ Oncology
___ E.N.T.	___ Ophthalmology
___ Gastroenterology	___ Orthopedics
___ General Surgery	___ Podiatry
___ Hematology	___ Urology

Primary Care Physician Signature: Gordon D Lemm MD

Specialist Name: Dr Von Dollen Tax ID #: _____

Specialist Address: 295 Posada Specialist Phone: 434-2262

Diagnosis, ICD 9 Code/Reason for Referral: atrial fib

Consultation: re-eval, fup x2 OV

Specific Treatment: (PCP must indicate what specific treatment he is authorizing if any with this visit)

SUBMIT CLAIMS TO: CCHP, P.O. BOX 4089, WOODLAND HILLS, CA 91367-4089

Coverage Limitations

1. **COVERAGE CONTINGENT ON ELIGIBILITY AT TIME OF SERVICE and within limits of benefit plan. Provider should contact CaliforniaCare Customer Service at the number indicated on the back of the members card to check eligibility.**

2. **All coverage must be made to CONTRACTED PROVIDERS.**

Note: 1) Fax original within 5 days to 781-8928. Retain original for medical record. 2) Give copy to member. 3) Give copy to specialist, if desired.

SM 4004 1/98

6-35

08/08/01 RECEIVED REFERRALS - DETAIL Page 1
COASTAL CARDIOLOGY, INC

6768.0 MCCORNACK, DANIEL E Insurance ID : NCF555517837

Referral Num	From Doctor	To Specialty	To Doctor	Type
PENDING	118 LEMM MD, CORDON	06 CARDIOLOGY	23 VON DOLLEN MD, LAWRENCE	REQ

Next Appt 02/07/02 Inpatient: N Reason : CARD Diagnostic Cardiology Pending Auth
Pri. Plan 1156.0 BC CALIF MSO PROC-AC9B Diag1 427.31 ATRIAL FIBRILLATION
Carrier BC BLUE CROSS Diag2 :
Sec. Plan 0.0 NONE Diag3 :
Sec Car. Diag4 :

Limit ID : None Dollars Allowed : .00 Visits Allowed : 0 Auth Date: 08/08/01 Start Dt 02/01/02
[ ] Used : .00 Used : 0 Auth Code: PENDING End Date 07/01/02
P.O S. . Ref Date 08/08/0.

********** Referral Narrative **********

*****REQUEST FOR SERVICES*****
PT DOB 2-15-63
WE ARE NEEDING A NEW AUTH FOR A 6 MONTH OFFICE VISIT DOS 2-7 02
EXPECTED CPT CODE, 99214
TEMP PHONE 434-2262 FAX 434-2843
THANK YOU, CATALINA

********** Referral Status **********

Authorization Requested From Plan Type: REQ - REQUESTED REFERRAL
---------- Overrides ---------- ---------- Issue Dates ----------
Results : None Returned Results:

Remaining Allowed Dollars: N/A Visits: N/A

6-36

* 7/26/01
Date

Fax to: (805) 781-3928
Phone: (805) 781-3929

ALL ITEMS NEED TO BE COMPLETED PRIOR TO REVIEW

Patient Name: Dan McCormack	Phone: 238-5208
Member ID: 555-51-7837	DOB: 2/15/65

SERVICES REQUESTED - RAF CANNOT BE PROCESSED WITHOUT THE FOLLOWING INFORMATION

Specialist/Provider Requested: Dr. Watson	Requested Date of Service/Procedure: PENDING
Tax ID: 770277685 Phone #: 805.434.0335	FAX: 805 484 1042 1
Place of Service or Diagnostic Procedure (if applicable) ☐ Outpatient Surgery/Test ☐ Consult ☐ Follow up ☐ Inpatient Estimated LOS:	
Tax ID:	
Description of service - CPT Code(s) # of Visits requested: EMG, NCS	ICD-9 Code(s) - Diagnosis: 355.8
Please provide SPECIFIC CLINICAL EXPLANATION/SPECIFIC SERVICE to support reason for request: 95861, 95900x6, 95903x6, 95904x6, 95934x2	

BLUE CROSS OF CALIFORNIA
DIRECTLY CONTRACTED PROVIDER NETWORK
Referral Authorization Form
☐ URGENT (Service Required within 24 Hours)

HOME HEALTH

Company Name:	Name/Title of requestor:
Start of Care (date)	# of total visits requested:

DME

Provider Name:		
Item(s) Requested	HCPS Code(s)	Expected Duration of Use: ☐ Rent ☐ Purchase Est. # Mths.:

REFERRING PHYSICIAN:

PCP Name: Leung		PCP Signature:	Date:
Physician Requesting Referral (if different from PCP)	Watson Yamaguchi	Phone: 805 434 0335	Fax: 805 434 0421
Was this referral generated at the request of the patient? ☐ Yes ☐ No			

FOR U.M. OFFICE USE ONLY

Services requested have been ☐ Denied (see comments) ☐ Pended (see comments) ☒ Approved Date Begin: 7/27/01 Date End: 9/27/01

Comments: as above

RECD 7/26/01
REVD 7/27/01
AUTH# 012080855
7/27/01

Authorized Signature:

LIMITATION OF COVERAGE: 1. Coverage continues on eligible [illegible] 2. ALL REFERRALS are subject to retrospective review

6-37

CaliforniaCare Directly Contracted Network in SLO County
Speedy Referral

Referral Number OTA

Patient Name: Dan McCornack	Birth Date: 2-15-63 Request Date: 7-26-01
PCP: Gordon Lemm Patient Ph.# 238-5208	Certificate # : NCF555517837 (Auth expires in 90 Days)

Express Referrals to the Following Contracted Specialists Only:

___ Cardiology	✓ Neurology
___ Dermatology	___ O.B./Gyn.
___ Endocrinology	___ Oncology
___ E.N.T.	___ Ophthalmology
___ Gastroenterology	___ Orthopedics
___ General Surgery	___ Podiatry
___ Hematology	___ Urology

Primary Care Physician Signature: Dr Gordon D Lemm MD

Specialist Name: Dr David Watson Tax ID #: 770277685

Specialist Address: 262 Posada Ln, Ste B, Templeton Specialist Phone: 434-0335

Diagnosis, ICD 9 Code/Reason for Referral: LE neuropathy 355.8

Consultation: consult & 2 fup OV

Specific Treatment: (PCP must indicate what specific treatment he is authorizing if any with this visit)

SUBMIT CLAIMS TO: CCHP, P.O. BOX 4089, WOODLAND HILLS, CA 91367-4089

Coverage Limitations

1. **COVERAGE CONTINGENT ON ELIGIBILITY AT TIME OF SERVICE and within limits of benefit plan. Provider should contact CaliforniaCare Customer Service at the number indicated on the back of the members card to check eligibility.**

2. **All coverage must be made to CONTRACTED PROVIDERS.**

ab FAXED 7-26-01

Note: 1) Fax original within 5 days to 781-8928. Retain original for medical record. 2) Give copy to member. 3) Give copy to specialist, if desired.

SM 4004 1/98

6-33

Gordon D. Lemm M.D.
292 Posada Lane Ste. D
Templeton, Ca. 93465

Faxed From: (805) 434-2019 **Phone: (805) 434-3211**

Sent To: Dr Watson

Fax Number: 434-0421

Content: referral for neuro pt: Dan McCormack
chart notes attached

Number of Pages: 4

All correspondence from this office is confidential.

Thank You!

please call pt to schedule an appt.
Thank you!

FAXED 7-26-01

6-39

07/05/01 RECEIVED REFERRALS - DETAIL Page 1
COASTAL CARDIOLOGY, INC.

6768.0 MCCORMACK, DANIEL E Insurance ID : NCP555517837

Referral Num	From Doctor	To Specialty	To Doctor	Type
PENDING	118 LEMM MD, GORDON	06 CARDIOLOGY	23 VON DOLLEN MD, LAWRENCE	REQ

Next Appt: 07/05/01 Inpatient: N Reason : CARD Diagnostic Cardiology Pending Auth
Pri. Plan: 1156.0 BC CALIF MSO PROC-AC9B Diag1 : 785.2 HEART MURMUR (NOS)
Carrier : BC BLUE CROSS Diag2 : 427.31 ATRIAL FIBRILLATION
Sec. Plan: 0.0 NONE Diag3 :
Sec. Car.: Diag4 :

Limit ID : None Dollars Allowed : .00 Visits Allowed : 0 Auth Date: 07/05/01 Start Dt: 07/05/01
[ ] Used : .00 Used : 0 Auth Code: PENDING End Date: 10/05/01
P.O.S. : Ref Date: 07/05/01

********** Referral Narrative **********

****REQUEST FOR SERVICES****
PT DOB 2-15-63
WE ARE NEEDING A NEW AUTH FOR A 1 MONTH OFFICE VISIT DOS 8-7-01.
EXPECTED CPT CODE: 99214
TEMP PHONE 434-2262 FAX 434-2843
THANK YOU, CATALINA

********** Referral Status **********

Authorization Requested From Plan Type: REQ - REQUESTED REFFERAL
---------- Overrides ---------- --------- Issue Dates ---------
Results : None Returned Results:

Remaining Allowed Dollars: N/A Visits: N/A

REQ 7/6/01
RCVD 7/9/01
AUTH# 011900078
ENTERED 7/9/01
KB

6-40

07/02/01 RECEIVED REFERRALS - DETAIL Page 1
COASTAL CARDIOLOGY, INC.

6768.0 MCCORNACK, DANIEL E Insurance ID : NCF555517837

Referral Num	From Doctor	To Specialty	To Doctor	Type
PENDING	118 LEMM MD, GORDON	06 CARDIOLOGY	23 VON DOLLEN MD, LAWRENCE	REQ

Next Appt : 07/05/01 Inpatient: N Reason : CARD Diagnostic Cardiology Pending Auth
Pri. Plan : 1156.0 BC CALIF MSO PROC-AC9B Diag1 : 427.31 ATRIAL FIBRILLATION
Carrier : BC BLUE CROSS Diag2 :
Sec. Plan : 0.0 NONE Diag3 :
Sec. Car. : Diag4 :

Limit ID : None Dollars Allowed : .00 Visits Allowed : 0 Auth Date: 07/05/01 Start Dt: 06/28/01
[ ] Used : .00 Used : 0 Auth Code: PENDING End Date: 09/28/01
P.O.S. : Ref Date: 06/28/01

********** Referral Narrative **********

REQUEST FOR SERVICES

PT DOB 02/15/63 DANIEL E MCCORMACK
REQUESTING AUTH FOR OV DOS 7/05/01
CPT CODE 99214 DX 427.31
PHONE 434-2262 FAX 434-0652
THANK YOU BRANDY

Urgent

********** Referral Status **********

Authorization Requested From Plan Type: REQ - REQUESTED REFFERAL
---------- Overrides ---------- ---------- Issue Dates ----------
Results : None Returned Results:

Remaining Allowed Dollars: N/A Visits: N/A

REC'D 7/2/01
REV'D 7/2/01
AUTH# 011830801
FAXED 7/2/01

6-41

CaliforniaCare Directly Contracted Network in SLO County
Speedy Referral

Referral Number OTA

Patient Name: Daniel McCornack | Birth Date: 2-15-63 | Request Date: 4-11-01

PCP: G. Lemm | Patient Ph.# 238 - 5208 | Certificate # : NCF - 555-51-7837 | (Auth expires in 90 Days)

Express Referrals to the Following Contracted Specialists Only:

- ✓ Cardiology
- ___ Dermatology
- ___ Endocrinology
- ___ E.N.T.
- ___ Gastroenterology
- ___ General Surgery
- ___ Hematology
- ___ Neurology
- ___ O.B./Gyn.
- ___ Oncology
- ___ Ophthalmology
- ___ Orthopedics
- ___ Podiatry
- ___ Urology

Primary Care Physician Signature: Gordon D Lemm MD

Specialist Name: Dr Vondellen | Tax ID #: ___

Specialist Address: 295 Rosado | Specialist Phone: 434-2262

Diagnosis, ICD 9 Code/Reason for Referral: Atrial Fib 427.31

Consultation: Re-eval, f/u-up (yearly)

Specific Treatment: (PCP must indicate what specific treatment he is authorizing if any with this visit)

SUBMIT CLAIMS TO: CCHP, P.O. BOX 4089, WOODLAND HILLS, CA 91367-4089

Coverage Limitations

1. COVERAGE CONTINGENT ON ELIGIBILITY AT TIME OF SERVICE and within limits of benefit plan. Provider should contact CaliforniaCare Customer Service at the number indicated on the back of the members card to check eligibility.
2. All coverage must be made to CONTRACTED PROVIDERS.

RECEIVED 5/14/01

Note: 1) Fax original within 5 days to 781-8928. Retain original for medical record. 2) Give copy to member. 3) Give copy to specialist, if desired.

6-42

Coastal Cardiology

Diplomates of American Board of Cardiology • Fellows of American College of Cardiology

FAX COVER SHEET

Date 5/11/01 Number or pages (including this sheet) 3 Time 4:35PM

To Geri
Individual FAX # Company

From Deanna Telephone number

MESSAGE Patient seen 4/11/01 for office visit with Dr. VonDollen. We need a retro auth for this visit.

Thanks for your help!

Deanna

The information contained in this telecopy message is intended only for the use of the individual or entity named above. If the reader of this message is not responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this message in error, please immediately notify us by telephone and return the original message to us at the above address via the U.S. Postal Service.

Thank you.

Note. We will ask Mary @ Blue Cross Blanket for his upcoming Echo & Holter

FAXED 6-43

Robert J. Doria, M.D., F.A.C.C. • Michael Famularo, M.D., F.A.C.C. • Lorianna P. Fletcher, M.D., F.A.C.C. • Gregory K. Jones, M.D. • Spencer L. Kulick, M.D., F.A.C.C.
Steven C. Pontius, M.D., F.A.C.C. • David M. Puro, M.D., F.A.C.C. • Mark J. Sada, M.D., F.A.C.C. • Lawrence Von Dollen, M.D., F.A.C.C. • Michael L. Wiechmann, M.D., F.A.C.C.

77 Casa Street, Suite 104
San Luis Obispo, California 93405
805/782-8844 · FAX: 805/782-8850

295 Posada Lane, Suite A
Templeton, California 93465
805/434-[illegible] · FAX: 805/434-2341

310 South Halcyon Road, Suite 105
Arroyo Grande, California 93420
805/[illegible]

05/11/01

RECEIVED REFERRALS - DETAIL
COASTAL CARDIOLOGY, INC.

6768.0 MCCORNACK, DANIEL E Insurance ID : NCF555517837

Referral Num	From Doctor	To Specialty	To Doctor	Type
PENDING	118 LEMM MD, GORDON	06 CARDIOLOGY	23 VON DOLLEN MD, LAWRENCE	REQ

Next Appt: 06/12/01 Inpatient: N Reason : CARD `Diagnostic Cardiology Pending Auth
Pri. Plan: 1156.0 BC CALIF MSO PROC-AC9B Diag1 : 427.31 ATRIAL FIBRILLATION
Carrier : BC BLUE CROSS Diag2 :
Sec. Plan: 0.0 NONE Diag3 :
Sec. Car.: Diag4 :

Limit ID : None Dollars Allowed : .00 Visits Allowed : 0 Auth Date: 05/11/01 Start Dt: 04/11/01
[ ] Used : .00 Used : 0 Auth Code: PENDING End Date: 08/11/01
P.O.S. : Ref Date: 05/11/01

********** Referral Narrative **********

REQUEST FOR RETRO AUTH.
PATIENT SEEN 4/11/01 BY DR VONDOLLEN W/O REFERRAL FOR THIS VISIT AS HMO.
PLEASE SEE PROGRESS NOTE FROM THAT DATE.
THANK YOU-DEANNA
TEMP FAX 434-2843 PHONE 434-2262

********** Referral Status **********

Authorization Requested From Plan Type: REQ - REQUESTED REFFERAL
---------- Overrides ---------- --------- Issue Dates ---------
Results : None Returned Results:

Remaining Allowed Dollars: N/A Visits: N/A

6-44

09/03/99 RECEIVED REFERRALS - DETAIL Page 1
COASTAL CARDIOLOGY, INC.

6768.0 MCCORNACK, DANIEL E Insurance ID : NCF555517837

Referral Num	From Doctor	To Specialty	To Doctor	Type
PENDING	118 LEMM MD, GORDON	06 CARDIOLOGY	23 VON DOLLEN MD, L TEMP	REQ

Next Appt: Inpatient: N Diag1 : 427.31 ATRIAL FIBRILLATION Pending Auth
Plan : 1156.0 BC CALIFORNIA CARE (HMO) Diag2 :
Carrier : BC BLUE CROSS Diag3 :
Reason : CARD `Diagnostic Cardiology Diag4 :

Limit ID None Dollars Allowed : .00 Visits Allowed : 0 Auth Date: 09/03/99 Start Dt: 09/01/99
[| Used : .00 Used : 0 Auth Code: PENDING End Date: 12/01/99
P.O.S. : Ref Date: 09/03/99

********** Referral Narrative **********

PATIENT CHANGED INSURANCE AND WE WERE UNAWARE THAT IT WAS NOW HMO. PATIENT
SEEN FOR OV, CODE, 99213
CAN YOU PLEASE FAX A RETRO FOR 9/1/99 VISIT??
THANK YOU-DEANNA
TEMP FAX 434-2843 PHONE 434-2262

DOB 2/15/63

No

********** Referral Status **********

Authorization Requested From Plan Type: REQ - REQUESTED REFFERAL
---------- Overrides ---------- --------- Issue Dates ---------
Results : None Returned Results:

Remaining Allowed Dollars: N/A Visits: N/A

FAXED

1999090719900006

MD

6-45

CAREMARK
It all starts with care℠

PLEASE PLACE IN PATIENT'S FILE

Gordon D. Lemm
292 Posada Ln Ste D
Templeton, CA 93465-0000

January 30, 2004

Regarding your patient: Daniel Mccornack
Date of Birth: 02/15/1963

Dear Dr. Gordon D. Lemm, MD ,

Your patient referenced above is a participant in Caremark's Prescription Drug Program through a sponsoring benefit provider. We feel it's important that you receive this documentation for your records because it relates to a change in drug, quantity, or length of therapy. This was discussed with you or your authorized agent previously by phone or facsimile.

Original Drug Therapy: **ZANTAC TAB 300MG TAKE 1 TABLET DAILY #90 X3 refill(s)**

New Drug Therapy: **RANITIDINE TAB 300MG TAKE 1 TABLET DAILY #90 X1 refill(s)**

The success of our program is enhanced by the effective two-way exchange of information between physicians and our pharmacy staff. We appreciate your responsiveness and encourage your feedback as we may have opportunities to contact you in the future.

If you have any questions, please contact Caremark Clinical Services Support Department at **1-800-224-1193.** Pharmacists are available from **7:00 a.m. to 9:00 p.m. CST, Monday through Friday**.

Sincerely,

Your Customer Care Pharmacist
Caremark Inc.

52-6007 25046I03 MPP046A DIS508 NIZATI 154627521

Participant privacy is important to us. Caremark holds any and all information about our participant's health in confidence.

6-46

Medical Problem (e.g. high blood pressure, ulcer, etc.)	Medications	Medication Allergies
possible ulcer in past	Tagamet	Ampicillin
heart problem - Heartbeat	Tenormin when needed	

Surgeries	Date	Serious Injuries	Date
knee surgery	10-92	2nd + 3rd degree facial	
Tonsils	1982-1983	burns.	1984

Tobacco Use ✓ occasional

Alcohol Use ✓

Caffeine Use ✓

Immunizations

DPT						DT			Pneumovax
OPV						T. Im Glob			Hem Inf B
Tine						PPD			Rubella
MMR						Flu Vac			Hep B Vac

Dan McCormick
Patient's Signature

238-5208
Telephone Number

6-47

CAREMARK 154627521

PRESCRIPTION CLARIFICATION REQUEST

Team 1

Please Reply Promptly

Received: 01/23/2004

Dear: **LEMM, GORDON D , MD**

The patient identified below is covered under the Caremark drug benefit program through a prescription benefit plan. This prescription **requires clarification** regarding a possible duplicate drug therapy.

Patient Name: MCCORNACK, DANIEL **Date of Birth:** 02/15/1963

Medication Ordered: DILTIAZEM CD CAP 180/24HR **Quantity:** 90 **Refills:** 3

Directions: TAKE 1 CAPSULE EVERY EVENING

Please indicate your response in the "Reply Here" section below and fax this form to Caremark when done. If you contact Caremark by telephone please have the following reference number available to facilitate locating the patient's file:

154627521

Rx Patient Name: **MCCORNACK, DANIEL** Date of Birth: 02/15/1963

Date: 1-28-04

Medication: DILTIAZEM CD CAP 180/24HR

Please clarify: **This medication creates a duplicate therapy with the patient's current medication: CARTIA XT CAP 300/24HR**

Reply here: (Print Clearly) He takes 180mg in the evening and 300mg in the morning to control rhythm problems

Physician Signature: G Lemm

FAXED BY: _____ (Full Name if other than physician)

FAX TO: 1-800-216-2808

(PLEASE DO NOT MAIL)

Caremark
800 BIERMANN COURT
MOUNT PROSPECT, IL 600562173

Dr's Name: LEMM, GORDON D, MD

Address: 292 POSADA LN STE D, TEMPLETON, CA 93465

Phone: (805) 434-3211

Fax #: (805) 434-2019

MT334
01/28/2004

FAXED

Reference: 154627521

Sincerely,

Your Customer Care Team
Caremark Inc.

To speak to a pharmacist call: 1-800-238-1216 from 8:00 a.m. to 4:30 p.m. CST, Monday - Friday.

6-48

CAREMARK

154627521

CASE MANAGEMENT REQUEST

Team 1

Please Reply Promptly

Received: 01/23/2004

Dear : **LEMM, GORDON D , MD**

Patient Name: **MCCORNACK, DANIEL** Date of Birth: 02/15/1963

Medication Ordered: **ZANTAC TAB 300MG** Quantity: 90 Refills: 3

Directions: **TAKE 1 TABLET DAILY**

The patient identified below is covered under a prescription benefit plan administered by Caremark. Please answer the following questions. If recommendations are made, we are asking you to consider them only if appropriate for your patient. If you contact Caremark by telephone please have the following reference number available to facilitate locating the patient's file.**154627521**

Rx Patient Name: **MCCORNACK, DANIEL** Date of Birth: 02/15/1963

Date: _____

Unless otherwise indicated, date used will be the date of your fax transmission

Medication: **ZANTAC TAB 300MG**

Directions: **TAKE 1 TABLET DAILY**

Quantity: **90**

Please respond to our questions below and return to Caremark

1. Diagnosis?: **What is the DIAGNOSIS for the use of the medication prescribed?** GERD

2. Reevaluation?: **If the patient will be re-evaluated in 3 to 6 months may we adjust the refills to coincide with the next re-evaluation? ( )3 months supply ( )6 months supply ( )no change in refills (Please Check)**

Physician Signature: _____ /Faxed By: _____

(Full Name if other than physician)

Your signature indicates this is a new prescription. Generic substitution will occur unless "Brand Medically Necessary" or "Dispense As Written" is written on this prescription. Please review date, drug, directions, quantity and refills.

FAXED 1/28/04

FAX TO: 1-800-216-2808

(PLEASE DO NOT MAIL)

Dr's Name: LEMM, GORDON D, MD

MT334

01/28/2004

Caremark
800 BIERMANN COURT
MOUNT PROSPECT, IL 600562173

Address: 292 POSADA LN STE D, TEMPLETON, CA 93465
Phone: (805) 434-3211
Fax #: (805) 434-2019

Reference # 154627521

Sincerely,

Your Customer Care Team
Caremark Inc.

To speak to a pharmacist call: 1-800-238-1216 from: 8:00 a.m. to 4:30 p.m. CST, Monday - Friday.

52-1081 25F079103 52229448 MPP-DX RE-EVAL MT334 01/28/2004 04:30:46 PM Team 1

6-49

CAREMARK 154627521

PRESCRIPTION CLARIFICATION REQUEST

Team 1

Please Reply Promptly

Received: 01/23/2004

Dear : **LEMM, GORDON D , MD**

The patient identified below is covered under the Caremark drug benefit program through a prescription benefit plan. This prescription **requires clarification** regarding a high drug dosage.

Patient Name: MCCORNACK, DANIEL **Date of Birth:** 02/15/1963

Medication Ordered: LANOXIN TAB 0.25MG **Quantity:** 180 **Refills:** 3

Directions: TAKE 1 TABLET TWICE A DAY

Please indicate your response in the "Reply Here" section below and fax this form to Caremark when done. If you contact Caremark by telephone please have the following reference number available to facilitate locating the patient's file:

154627521

Rx Patient Name: **MCCORNACK, DANIEL** Date of Birth: 02/15/1963

Date: 1-28-04

Medication: LANOXIN TAB 0.25MG

Please clarify: **This prescription exceeds the maximum recommended daily dosage of: 1.00 TAB**

Reply here: (Print Clearly) Patient has atrial dysrhythmia and takes 2 tabs daily - He has a therapeutic level

Physician Signature: G Lemm

FAXED 1/28/04

FAXED BY: _____

(Full Name if other than physician)

FAX TO: 1-800-216-2808

(PLEASE DO NOT MAIL)

Dr's Name: LEMM, GORDON D, MD

MT334

01/28/2004

Caremark
800 BIERMANN COURT
MOUNT PROSPECT, IL 600562173

Address: 292 POSADA LN STE D, TEMPLETON, CA 93465
Phone: (805) 434-3211
Fax #: (805) 434-2019

Reference # 154627521

Sincerely,

Your Customer Care Team
Caremark Inc.

To speak to a pharmacist call: 1-800-238-1216 from 8:00 a.m. to 4:30 p.m. CST, Monday - Friday.

6-50

Precision Rx-

GORDON D. LEMM, M.D.
292 POSADA LANE, SUITE D
TEMPLETON, CA 93465
(805) 434-3211 TEL.
DEA # AL 1051363
LIC. # G44422

NAME McConnack, Dan AGE
ADDRESS DATE 11-25-03
Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

℞

1. Lanoxin .25mg #180
ī bid

2. Diltiazem 300mg #90
ī q Am

3. Diltiazem 180mg #90
ī q Pm

FAXED 11/25/03

Refill 3 times

DO NOT SUBSTITUTE ☐ J Lemm MD

To ensure brand name dispensing, check and initial box.

2FFP1132847

Address: 6255 Peachy Canyon Rd
Paso Robles Ca 93446

Phone #: (805) 238-5208
SSN: 555-51-7837
DOB: 2/15/63
Blue Cross Point of Service
Group # 5710916E

6-51
(800) 905-9815

Precision Rx –

GORDON D. LEMM, M.D.
292 POSADA LANE, SUITE D
TEMPLETON, CA 93465
(805) 434-3211 TEL.
DEA # AL 1051363
LIC. # G44422

NAME McCormack, Dan AGE ____
ADDRESS ____ DATE 11-20-02
Rx ILLEGAL IF NOT SAFETY BLUE BACKGROUND

℞

1. Diltiazem 300mg #60
Sig: 1 po qAm
2. Diltiazem 180mg #60
Sig: 1 po q PM
3. Lanoxin .25mg #120
Sig: 1 po bid

800-905-9815

Refill 6 times

DO NOT SUBSTITUTE ☐ G Lemm

To ensure brand name dispensing, check and initial box.

1KFP1132847

FAXED Time: Date: 11/20/02

Address: 6255 Peachy Canyon Rd
Paso Robles Ca 93446

Phone #: (805) 238-5208
SSN: 555-51-7837
DOB: 2/15/63
Blue Cross Point of Service
Group # 570096E

6-52
(800) 905-9815

DEA # AL1051363

GORDON D. LEMM, M.D.
DIPLOMATE AMERICAN BOARD OF FAMILY PRACTICE
292 POSADA LANE - SUITE D
TEMPLETON, CA 93465
805-434-3211 FAX: 805-434-2019
CA LIC NO. G 44422

NAME Mc Cornack, Dan

ADDRESS _____ DATE 7-16-02

℞ (Please Print)

Diltiazem 300mg #90
1 g AM

Diltiazem 180mg #90
1 gPm

FAXED 7-16-02

☐ LABEL

REFILL 3 TIMES PRN NR

☐ DO NOT SUBSTITUTE _____ M.D.

TO INSURE BRAND NAME DISPENSING, CHECK AND INITIAL BOX.

22-MAR-01 01-100063374-7-24406_0002

Pt info: 6255 Peachy Canyon Rd
Paso Robles Ca 93446
(805) 238-5208
SSN# 555-51-7837
DOB: 2-15-63

Faxed From Dr. Lemm's office by
Audra R. RMA

6-53